

Commentary

Academic Physicians, Clinical Investigators, and Managed Care Whither Hippocrates?

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It has been my distinct pleasure to serve as President of the Western Association of Physicians since February 1995. I could select from many subjects for a presidential perspective in this era of dramatic advances occurring in the science of medicine in parallel with what are equally dramatic steps backward in the way medicine is practiced. Instead, I will share some thoughts about the unique role of academic physicians and clinical researchers, including their ethical precepts and achievements.

To anyone who reads the lay press, it is obvious that medicine is no longer perceived in the same favorable light as it was a generation ago. This is true despite incredible advances in biomedical science brought about through basic biomedical research, much of which was carried out at the bench and translated to the bedside by physician investigators such as those represented by this association. The improvement in age-adjusted mortality over this period from 1950 to the present is staggering, considering that the manipulation of "risk factors" is relatively recent (Figure 1). I believe that these changes are more likely related to improved patient care. We need only to think of the fact that today, coronary artery bypass surgery can be done with less than 1% mortality; that heart, kidney, and liver transplant graft survival from unrelated donors approaches 90% at one year; that recombinant human erythropoietin is used routinely in medical practice; and that diseases such as leukemia and other formerly fatal cancers have high remission rates and even cures. It is possible to go on and on about the achievements of medical science and medical research. Yet, policymakers, the public, and even leaders in medicine are dissatisfied. They talk about the fact that medical care is too expensive. Is medical care really too expensive, or is too much being taken in profit or spent on marketing and administration? John Kitzhaber, MD, the physician-governor of Oregon, recently uttered the following statement at the Oregon meeting of the American College of Physicians, "The Hippocratic Oath

is outdated for the 20th century," in defense of the priority list of the controversial Oregon Health Plan. Dr Kitzhaber was discussing the ethical dilemmas faced by physicians in providing the best medical care for individual patients.¹ Merwyn Greenlick, PhD, Chair of the Oregon Health Sciences University Department of Public Health, talks about a new paradigm for providing medical care, "population medicine," again as opposed to the traditional doctor-patient relationship (oral communication, October 1994). If this euphemism that presumably means doing the greatest good for the greatest number of people with the dollars available is translated by health care professionals to treating only patients with good prognoses or caring for healthy low-risk people, the results will be disastrous. The concept of managed care has been embraced both as a money-saving device and as a way to implement important preventive services. These trends have led to the assumptions that the quality of medical care is reflected by and can be improved by unproven programs, such as population cholesterol screening,² adult immunization programs, and other untested strategies. Physician performance in these managed care systems is measured by "productivity quotas" and other measures having little relationship to physician quality (Figure 2).³ Further, it is assumed by health maintenance organization administrators and leaders that the medical practitioners needed to carry these types of advances forward are less well-trained physicians or physician extenders who will be cost-effective and will, they also assume, function without decreasing the quality of medical care. While patient satisfaction surveys are marketed and promoted by those providing care in this way, the relatively silent lower income groups are not so sure (Figure 3).^{4,5}

It is my view and my message that academic medicine as practiced by physician investigators, particularly in academic settings, has rolled over too easily to these untested assumptions. I am embarrassed to acknowledge

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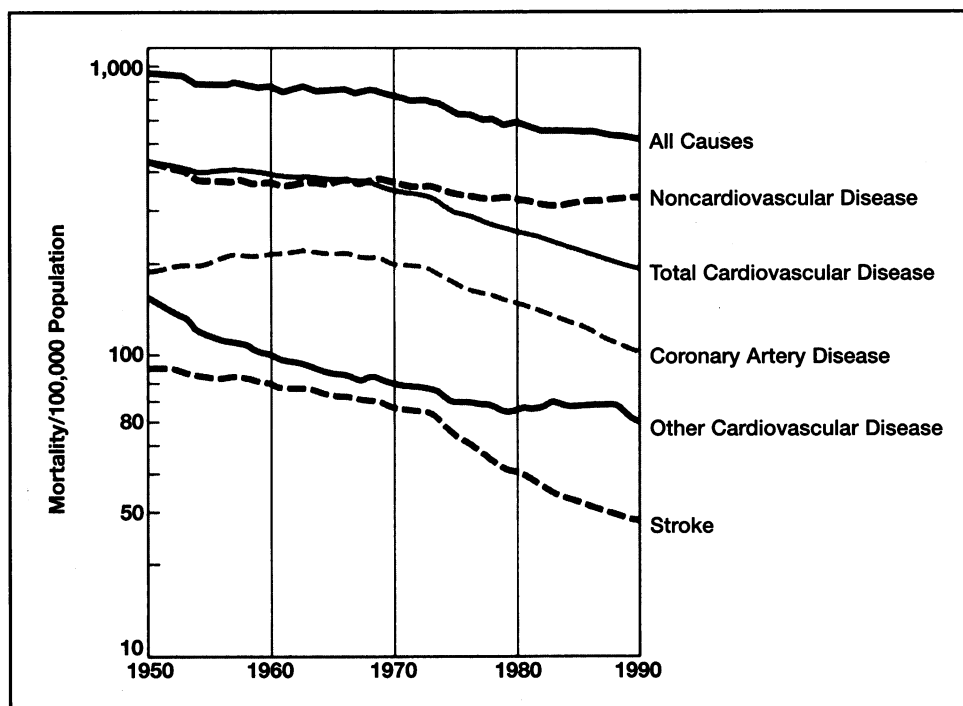


Figure 1.—The age-adjusted mortality in the United States for 1950 through 1990 is shown.

that many of those who have rolled over have been prominent academic leaders whose own career paths to the top were dependent on their contributions as physician-scientists. Can you imagine asking an institutional review board to approve an experiment in which one outcome might be a decreased quality of medical care without asking the permission of patients involved, much less obtaining any type of informed consent? No one would let you do that experiment. Yet, this is precisely what managed care does, without the consent of patients. Does it really make sense for less well-trained physicians and physician extenders to look after patients with complicated medical conditions such as leukemia, organ transplantation, the acquired immunodeficiency syndrome, and oncologic problems, for which specialists and clinical investigators have provided a sophisticated level of medical care that is unparalleled in the world? Is there any situation you can think of in medicine, or with any other form of intellectual pursuit,

where reducing the knowledge base of the providers has improved the outcome?

These new trends in the delivery of health care, which have largely gone unchallenged, will create a new minority group, namely, the "seriously ill." Furthermore, in this rush to provide 1996 care more broadly, or more cheaply, no thought is given to money for research or even the training of the next generation of physicians who will be needed to translate the excitement and investment of bench research to the bedside. Managed care pays for none of the freight of its talent while enjoying the largesse of federally supported training programs. There has been a decline of more than 70% in research applications to the National Institutes of Health from physician-scientists in the past several years.⁶ Moreover, many of us who have served as program directors in the past several years can attest to the fact that interest in careers in biomedical research by today's young physicians approaches zero. Why should talented persons, who for many years have studied hard and ranked at the top of their classes, select a career path that seems so obviously underappreciated and unsupported by today's society?

Many factors that have accounted for our current situation are clearly beyond our control. But as physicians and physician-clinical investigators interested in our patients and the advancement of medical science, we have some options available. I propose the following actions:

- First and foremost, we can speak out for our patients. When, in our judgment, it is not in a patient's best interest for a medical procedure to be either denied

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| <p>9 measures of quality</p> <p>5 measures of access to care and satisfaction with care</p> <p>15 measures of membership and utilization—procedure and hospital admission rates for various conditions</p> <p>15 measures of finance—loss ratios, liquidity, and financial reserves</p> <p>15 measures of structure and management—board certification, turnover of physicians, case management, and utilization review</p> |
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Figure 2.—The content of health plan employer data and information set is shown.

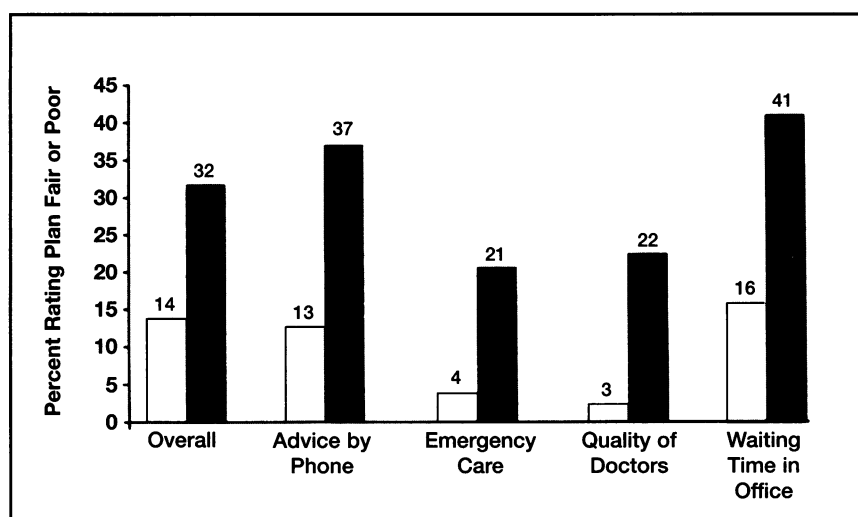


Figure 3.—The experiences of low-income patients (annual income <\$15,000) in managed care are shown (from Louis Harris and Associates⁵). White bars = fee-for-service patients, black bars = patients in managed care.

or approved, we must advocate for that patient with the system. No one else will do it. I believe Dr Kitzhaber was mistaken; the Hippocratic Oath is very relevant for the 21st century. We need to watch for and speak out against the inherent conflict of interest whereby incentives are put into medical practice for financial and other reasons dissociated from patients' best interest. Fortunately, Oregon will not ration care because no one there has the political will to "go down the list" of prioritized procedures. There are few data about the long-term financial viability of the Oregon Health Plan (as mandated by law), but there are indications that it is an artistic disaster in deep financial trouble (Julie Ferguson, Vice President, Health Systems and Quality, Physicians Association of Clackamas County), written communication, January 29, 1996). It should be noted that Oregon has been able to ration only for the poor and not the entire state, as planned. In 1991 then-Senator Albert Gore said, "But Oregon has made a tragic choice and a horrible mistake in responding to the plight of the uninsured by developing a scheme that takes from the poor to help the poor, that preys on the limited political clout of poor women and children, and whose only answer to skyrocketing health-care costs is to ration care." The Oregon plan "is a declaration of unconditional surrender just as the first battles are being fought over the future of our health-care system."⁷

- We must continue to advocate for the training and development of basic and clinical investigators. The American Board of Internal Medicine is proposing a shortening of generalist training in internal medicine with an extension of research training, both in basic and clinical science, to produce a generation of subspecialists that can translate the tremendous advances of science to the bedside.⁸

- We should endorse the principal-care concept and disease management organizations. This concept states

that an internal medicine specialist or subspecialist can best serve as the primary care physician and coordinate care for patients whose medical condition requires and deserves such subspecialty intervention. Obvious examples are oncologic problems, chronic renal failure, end-stage heart disease, organ transplantation, chronic rheumatoid arthritis, and brittle diabetes mellitus.

- We should mobilize our patients. The patients are the victims of the processes we are discussing, not us. Their children will suffer the consequences of the demise of the biomedical research enterprise in this country and the loss of global leadership in this area that the United States has always enjoyed. Moreover, it is only the patients, not us, who have the political credibility to reverse the current trends. The burden of proof for the throwing away of the past 30 years of medical advances should be shifted to the people who want to do something radically different without any proof of safety and efficacy.

- Physician-clinical investigators need to take a responsible role with the media. We need to educate the next generation of consumers about the processes of science, the pitfalls of "magic bullets," the way new drugs become approved, and all the things that, when twisted by reporters looking for a story, unfairly raise expectations and lead to a loss of confidence in the whole medical enterprise. We need only look as far as the supermarket, the television, and the popular press to see how many billions of dollars, which could be used to provide traditional medical care, are spent on alternative medicines, tonics, vitamins, and herbal remedies.

- If we really want to improve the public health, it might not be done through a medical model at all. The medical problems associated with tobacco, alcohol, and illicit drug use, related domestic violence, and trauma represent the major portion of health care costs.^{9,10} If these societal problems were addressed with political

TABLE 1.—*The Health and Financial Effects of Prohibition in the United States**

Variable	Effect
Deaths due to overdose and impure alcohol, No.	1,000/yr
Alcohol use in US.	Dropped by 50%/yr
Deaths due to cirrhosis.	Dropped by 64%/yr
Mental health admissions due to alcohol.	Dropped by 53%/yr
Alcohol-related deaths in US, 1992-1995, No.	125,000/yr
Cost of alcohol-related health, motor vehicle accidents, crime, \$	140 billion
Taxes collected, \$.	20 billion

*From M. H. Moore, *The New York Times*, Oct 16, 1989, p A21.

The social contract of American medicine presupposes that physicians are patients' advocates, not advocates for society against patients whose care is costly or patients whose condition is such that physicians cannot be sure that procedures undertaken will have a high likelihood of long-term benefit.

Figure 4.—The ethics against the rationing of medical services by a physician are spelled out (from Burck et al¹²).

will, any appropriate medical care for the sick could be easily afforded. The incidence of these totally preventable medical problems is escalating, however, eroding the nation's limited health care funds. It is of interest to look at the data from the period of alcohol prohibition so reviled by revisionist history. From a public health standpoint, it was a booming success (M. H. Moore, "Actually Prohibition Was a Success," *The New York Times*, October 16, 1989, p A21) (Table 1).¹¹ Physicians need to stand up and speak out and take an active role in helping to educate and politically influence society to set the practice of medicine back on track.

In conclusion, we need, like no other time in history, to continue to advocate for our patients and to speak out against the rush to make medical care just another product to be sold on the open market. Medicine is not a business. It is a profession with a high calling and ideals that are as relevant today as they have ever been, perhaps more so (Figure 4).¹² If we, who are the leaders in medicine, allow these changes to occur without speaking out, we will be as guilty as the chief executive officers of managed care organizations who sacrifice quality in return for pocketing millions of dollars in salary. This corporate culture of medicine will be the savings and loan debacle of the 1990s.

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